

INSURANCE CODE

TITLE 8. HEALTH INSURANCE AND OTHER HEALTH COVERAGES

SUBTITLE F. PHYSICIANS AND HEALTH CARE PROVIDERS

CHAPTER 1452. PHYSICIAN AND PROVIDER CREDENTIALS

SUBCHAPTER A. CREDENTIALING OF PHYSICIANS AND PROVIDERS BY HEALTH  
MAINTENANCE ORGANIZATION

Sec. 1452.001. APPLICABILITY OF CERTAIN DEFINITIONS. In this subchapter, a term defined by Section [843.002](#) has the meaning assigned by that section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1452.002. VERIFICATION OF PHYSICIAN'S LICENSE OR CERTIFICATE. The commissioner shall require a health maintenance organization to verify that a physician's license to practice medicine and any other certificate the physician is required to hold, including a certificate issued by the Department of Public Safety or the federal Drug Enforcement Administration or a certificate issued under the Medicare program, is valid as of the date of:

- (1) initial credentialing of the physician; and
- (2) each recredentialing.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1452.003. SITE VISIT FOR INITIAL CREDENTIALING. (a) The commissioner shall require a health maintenance organization that conducts a site visit for the purpose of initial credentialing of a physician or provider to evaluate during the visit a site's accessibility, appearance, space, medical or dental recordkeeping practices, availability of appointments, and confidentiality procedures.

(b) The commissioner may not require the health maintenance organization to evaluate the appropriateness of equipment during the site visit.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1452.004. LIMITATION ON COMMISSIONER'S AUTHORITY. The commissioner may not require a health maintenance organization to:

(1) formally recredential a physician or provider more frequently than once in any three-year period;

(2) verify the validity of a license or certificate held by a physician as of a date other than the date of initial credentialing or recredentialing of the physician;

(3) use clinical personnel to perform a site visit for initial credentialing of a physician or provider unless clinical review is needed during the site visit; or

(4) require a site visit be performed for the purpose of recredentialing of a physician or provider.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1452.005. SITE VISIT FOR CAUSE NOT PRECLUDED. This subchapter does not preclude a health maintenance organization from conducting a site visit of a physician or provider at any time for cause, including a complaint made by a member or another external complaint made to the health maintenance organization.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1452.006. RULES RELATED TO SELECTION OF PHYSICIANS AND PROVIDERS BY HEALTH MAINTENANCE ORGANIZATION. A rule adopted by the commissioner under Section [843.102](#) that relates to implementation and maintenance by a health maintenance organization of a process for selecting and retaining affiliated physicians and providers must comply with:

(1) this subchapter; and

(2) standards adopted by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

#### SUBCHAPTER B. STANDARDIZED FORMS

Sec. 1452.051. DEFINITIONS. In this subchapter:

(1) "Advanced practice nurse" has the meaning assigned

by Section 301.152, Occupations Code.

(2) "Physician" means an individual licensed to practice medicine in this state.

(3) "Physician assistant" means an individual who holds a license issued under Chapter 204, Occupations Code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.045(a), eff. September 1, 2005.

Sec. 1452.052. STANDARDIZED FORM FOR VERIFICATION OF CREDENTIALS. (a) The commissioner by rule shall:

(1) prescribe a standardized form for the verification of the credentials of a physician, advanced practice nurse, or physician assistant; and

(2) require a public or private hospital, a health maintenance organization operating under Chapter 843, or the issuer of a preferred provider benefit plan under Chapter 1301 to use the form for verification of credentials.

(b) In prescribing a form under this section, the commissioner shall consider any credentialing application form that is widely used in this state or any form currently used by the department.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.045(a), eff. September 1, 2005.

#### SUBCHAPTER C. EXPEDITED CREDENTIALING PROCESS FOR CERTAIN PHYSICIANS

Sec. 1452.101. DEFINITIONS. In this subchapter:

(1) "Applicant physician" means a physician applying for expedited credentialing under this subchapter.

(2) "Enrollee" means an individual who is eligible to receive health care services under a managed care plan.

(3) "Health care provider" means:

(A) an individual who is licensed, certified, or otherwise authorized to provide health care services in this state; or

(B) a hospital, emergency clinic, outpatient clinic, or other facility providing health care services.

(4) "Managed care plan" means a health benefit plan under which health care services are provided to enrollees through contracts with health care providers and that requires enrollees to use participating providers or that provides a different level of coverage for enrollees who use participating providers. The term includes a health benefit plan issued by:

(A) a health maintenance organization;

(B) a preferred provider benefit plan issuer; or

(C) any other entity that issues a health benefit plan, including an insurance company.

(5) "Medical group" means:

(A) a single legal entity owned by two or more physicians;

(B) a professional association composed of licensed physicians;

(C) any other business entity composed of licensed physicians as permitted under Subchapter B, Chapter 162, Occupations Code; or

(D) two or more physicians on the medical staff of, or teaching at, a medical school or medical and dental unit, as defined or described by Section 61.003, 61.501, or 74.601, Education Code.

(6) "Participating provider" means a health care provider who has contracted with a health benefit plan issuer to provide services to enrollees.

Added by Acts 2007, 80th Leg., R.S., Ch. 1203 (H.B. 1594), Sec. 1, eff. September 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 296 (H.B. 389), Sec. 1, eff. September 1, 2009.

Acts 2011, 82nd Leg., R.S., Ch. 414 (S.B. 822), Sec. 1, eff. September 1, 2011.

Sec. 1452.102. APPLICABILITY. This subchapter applies only to a physician who joins an established medical group that has a current contract in force with a managed care plan.

Added by Acts 2007, 80th Leg., R.S., Ch. 1203 (H.B. 1594), Sec. 1, eff. September 1, 2007.

Sec. 1452.103. ELIGIBILITY REQUIREMENTS. To qualify for expedited credentialing under this subchapter and payment under Section 1452.104, an applicant physician must:

(1) be licensed in this state by, and in good standing with, the Texas Medical Board;

(2) submit all documentation and other information required by the issuer of the managed care plan as necessary to enable the issuer to begin the credentialing process required by the issuer to include a physician in the issuer's health benefit plan network; and

(3) agree to comply with the terms of the managed care plan's participating provider contract currently in force with the applicant physician's established medical group.

Added by Acts 2007, 80th Leg., R.S., Ch. 1203 (H.B. 1594), Sec. 1, eff. September 1, 2007.

Sec. 1452.104. PAYMENT OF APPLICANT PHYSICIAN DURING CREDENTIALING PROCESS. On submission by the applicant physician of the information required by the managed care plan issuer under Section 1452.103(2), and for payment purposes only, the issuer shall treat the applicant physician as if the physician were a participating provider in the health benefit plan network when the applicant physician provides services to the managed care plan's enrollees, including:

(1) authorizing the applicant physician to collect copayments from the enrollees; and

(2) making payments to the applicant physician.

Added by Acts 2007, 80th Leg., R.S., Ch. 1203 (H.B. 1594), Sec. 1, eff. September 1, 2007.

Sec. 1452.105. DIRECTORY ENTRIES. Pending the approval of an application submitted under Section [1452.104](#), the managed care plan may exclude the applicant physician from the managed care plan's directory of participating physicians, the managed care plan's website listing of participating physicians, or any other listing of participating physicians.

Added by Acts 2007, 80th Leg., R.S., Ch. 1203 (H.B. [1594](#)), Sec. 1, eff. September 1, 2007.

Sec. 1452.106. EFFECT OF FAILURE TO MEET CREDENTIALING REQUIREMENTS. If, on completion of the credentialing process, the managed care plan issuer determines that the applicant physician does not meet the issuer's credentialing requirements:

(1) the managed care plan issuer may recover from the applicant physician or the physician's medical group an amount equal to the difference between payments for in-network benefits and out-of-network benefits; and

(2) the applicant physician or the physician's medical group may retain any copayments collected or in the process of being collected as of the date of the issuer's determination.

Added by Acts 2007, 80th Leg., R.S., Ch. 1203 (H.B. [1594](#)), Sec. 1, eff. September 1, 2007.

Sec. 1452.107. ENROLLEE HELD HARMLESS. An enrollee in the managed care plan is not responsible and shall be held harmless for the difference between in-network copayments paid by the enrollee to a physician who is determined to be ineligible under Section [1452.106](#) and the managed care plan's charges for out-of-network services. The physician and the physician's medical group may not charge the enrollee for any portion of the physician's fee that is not paid or reimbursed by the enrollee's managed care plan.

Added by Acts 2007, 80th Leg., R.S., Ch. 1203 (H.B. [1594](#)), Sec. 1, eff. September 1, 2007.

Sec. 1452.108. LIMITATION ON MANAGED CARE ISSUER LIABILITY. A managed care plan issuer that complies with this subchapter is not subject to liability for damages arising out of or

in connection with, directly or indirectly, the payment by the issuer of an applicant physician as if the physician were a participating provider in the health benefit plan network.  
Added by Acts 2007, 80th Leg., R.S., Ch. 1203 (H.B. [1594](#)), Sec. 1, eff. September 1, 2007.

SUBCHAPTER D. EXPEDITED CREDENTIALING PROCESS  
FOR CERTAIN PODIATRISTS

Sec. 1452.151. DEFINITIONS. In this subchapter:

(1) "Applicant podiatrist" means a podiatrist applying for expedited credentialing under this subchapter.

(2) "Enrollee" means an individual who is eligible to receive health care services under a managed care plan.

(3) "Health care provider" means:

(A) an individual who is licensed, certified, or otherwise authorized to provide health care services in this state; or

(B) a hospital, emergency clinic, outpatient clinic, or other facility providing health care services.

(4) "Managed care plan" means a health benefit plan under which health care services are provided to enrollees through contracts with health care providers and that requires enrollees to use participating providers or that provides a different level of coverage for enrollees who use participating providers. The term includes a health benefit plan issued by:

(A) a health maintenance organization;

(B) a preferred provider benefit plan issuer; or

(C) any other entity that issues a health benefit plan, including an insurance company.

(5) "Participating provider" means a health care provider who has contracted with a health benefit plan issuer to provide services to enrollees.

(6) "Professional practice" means a business entity that is owned by one or more podiatrists or physicians.

Added by Acts 2013, 83rd Leg., R.S., Ch. 79 (S.B. [365](#)), Sec. 1, eff. September 1, 2013.

Sec. 1452.152. APPLICABILITY. This subchapter applies only to a podiatrist who joins an established professional practice that has a current contract in force with a managed care plan.

Added by Acts 2013, 83rd Leg., R.S., Ch. 79 (S.B. 365), Sec. 1, eff. September 1, 2013.

Sec. 1452.153. ELIGIBILITY REQUIREMENTS. To qualify for expedited credentialing under this subchapter and payment under Section 1452.154, an applicant podiatrist must:

(1) be licensed as a podiatrist in this state by, and be in good standing with, the Texas Department of Licensing and Regulation;

(2) submit all documentation and other information required by the issuer of the managed care plan as necessary to enable the issuer to begin the credentialing process required by the issuer to include a podiatrist in the issuer's health benefit plan network; and

(3) agree to comply with the terms of the managed care plan's participating provider contract currently in force with the applicant podiatrist's established professional practice.

Added by Acts 2013, 83rd Leg., R.S., Ch. 79 (S.B. 365), Sec. 1, eff. September 1, 2013.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 467 (H.B. 4170), Sec. 19.016, eff. September 1, 2019.

Sec. 1452.154. PAYMENT OF APPLICANT PODIATRIST DURING CREDENTIALING PROCESS. On submission by the applicant podiatrist of the information required by the managed care plan issuer under Section 1452.153(2), and for payment purposes only, the issuer shall treat the applicant podiatrist as if the podiatrist were a participating provider in the health benefit plan network when the applicant podiatrist provides services to the managed care plan's enrollees, including:

(1) authorizing the applicant podiatrist to collect copayments from the enrollees; and



(2) making payments to the applicant podiatrist.

Added by Acts 2013, 83rd Leg., R.S., Ch. 79 (S.B. 365), Sec. 1, eff. September 1, 2013.

Sec. 1452.155. DIRECTORY ENTRIES. Pending the approval of an application submitted under Section 1452.154, the managed care plan may exclude the applicant podiatrist from the managed care plan's directory of participating podiatrists, the managed care plan's website listing of participating podiatrists, or any other listing of participating podiatrists.

Added by Acts 2013, 83rd Leg., R.S., Ch. 79 (S.B. 365), Sec. 1, eff. September 1, 2013.

Sec. 1452.156. EFFECT OF FAILURE TO MEET CREDENTIALING REQUIREMENTS. If, on completion of the credentialing process, the managed care plan issuer determines that the applicant podiatrist does not meet the issuer's credentialing requirements:

(1) the managed care plan issuer may recover from the applicant podiatrist or the podiatrist's professional practice an amount equal to the difference between payments for in-network benefits and out-of-network benefits; and

(2) the applicant podiatrist or the podiatrist's professional practice may retain any copayments collected or in the process of being collected as of the date of the issuer's determination.

Added by Acts 2013, 83rd Leg., R.S., Ch. 79 (S.B. 365), Sec. 1, eff. September 1, 2013.

Sec. 1452.157. ENROLLEE HELD HARMLESS. An enrollee in the managed care plan is not responsible and shall be held harmless for the difference between in-network copayments paid by the enrollee to a podiatrist who is determined to be ineligible under Section 1452.156 and the managed care plan's charges for out-of-network services. The podiatrist and the podiatrist's professional practice may not charge the enrollee for any portion of the podiatrist's fee that is not paid or reimbursed by the enrollee's managed care plan.

Added by Acts 2013, 83rd Leg., R.S., Ch. 79 (S.B. [365](#)), Sec. 1, eff. September 1, 2013.

Sec. 1452.158. LIMITATION ON MANAGED CARE ISSUER LIABILITY. A managed care plan issuer that complies with this subchapter is not subject to liability for damages arising out of or in connection with, directly or indirectly, the payment by the issuer of an applicant podiatrist as if the podiatrist were a participating provider in the health benefit plan network.

Added by Acts 2013, 83rd Leg., R.S., Ch. 79 (S.B. [365](#)), Sec. 1, eff. September 1, 2013.

#### SUBCHAPTER E. EXPEDITED CREDENTIALING PROCESS FOR CERTAIN THERAPEUTIC OPTOMETRISTS

Sec. 1452.201. DEFINITIONS. In this subchapter:

(1) "Applicant therapeutic optometrist" means a therapeutic optometrist applying for expedited credentialing under this subchapter.

(2) "Enrollee" means an individual who is eligible to receive health care services under a managed care plan.

(3) "Health care provider" has the meaning assigned by Section [1452.151](#).

(4) "Managed care plan" has the meaning assigned by Section [1452.151](#).

(5) "Participating provider" means a health care provider who has contracted with a health benefit plan issuer to provide services to enrollees.

(6) "Professional practice" means a business entity that is owned by one or more therapeutic optometrists or physicians.

Added by Acts 2013, 83rd Leg., R.S., Ch. 79 (S.B. [365](#)), Sec. 1, eff. September 1, 2013.

Sec. 1452.202. APPLICABILITY. This subchapter applies only to a therapeutic optometrist who joins an established professional practice that has a current contract in force with a

managed care plan.

Added by Acts 2013, 83rd Leg., R.S., Ch. 79 (S.B. 365), Sec. 1, eff. September 1, 2013.

Sec. 1452.203. ELIGIBILITY REQUIREMENTS. To qualify for expedited credentialing under this subchapter and payment under Section 1452.204, an applicant therapeutic optometrist must:

(1) be licensed in this state by, and in good standing with, the Texas Optometry Board;

(2) submit all documentation and other information required by the issuer of the managed care plan as necessary to enable the issuer to begin the credentialing process required by the issuer to include a therapeutic optometrist in the issuer's health benefit plan network; and

(3) agree to comply with the terms of the managed care plan's participating provider contract currently in force with the applicant therapeutic optometrist's established professional practice.

Added by Acts 2013, 83rd Leg., R.S., Ch. 79 (S.B. 365), Sec. 1, eff. September 1, 2013.

Sec. 1452.204. PAYMENT OF APPLICANT THERAPEUTIC OPTOMETRIST DURING CREDENTIALING PROCESS. On submission by the applicant therapeutic optometrist of the information required by the managed care plan issuer under Section 1452.203(2), and for payment purposes only, the issuer shall treat the applicant therapeutic optometrist as if the therapeutic optometrist were a participating provider in the health benefit plan network when the applicant therapeutic optometrist provides services to the managed care plan's enrollees, including:

(1) authorizing the applicant therapeutic optometrist to collect copayments from the enrollees; and

(2) making payments to the applicant therapeutic optometrist.

Added by Acts 2013, 83rd Leg., R.S., Ch. 79 (S.B. 365), Sec. 1, eff. September 1, 2013.

Sec. 1452.205. DIRECTORY ENTRIES. Pending the approval of an application submitted under Section [1452.204](#), the managed care plan may exclude the applicant therapeutic optometrist from the managed care plan's directory of participating therapeutic optometrists, the managed care plan's website listing of participating therapeutic optometrists, or any other listing of participating therapeutic optometrists.

Added by Acts 2013, 83rd Leg., R.S., Ch. 79 (S.B. [365](#)), Sec. 1, eff. September 1, 2013.

Sec. 1452.206. EFFECT OF FAILURE TO MEET CREDENTIALING REQUIREMENTS. If, on completion of the credentialing process, the managed care plan issuer determines that the applicant therapeutic optometrist does not meet the issuer's credentialing requirements:

(1) the managed care plan issuer may recover from the applicant therapeutic optometrist or the therapeutic optometrist's professional practice an amount equal to the difference between payments for in-network benefits and out-of-network benefits; and

(2) the applicant therapeutic optometrist or the therapeutic optometrist's professional practice may retain any copayments collected or in the process of being collected as of the date of the issuer's determination.

Added by Acts 2013, 83rd Leg., R.S., Ch. 79 (S.B. [365](#)), Sec. 1, eff. September 1, 2013.

Sec. 1452.207. ENROLLEE HELD HARMLESS. An enrollee in the managed care plan is not responsible and shall be held harmless for the difference between in-network copayments paid by the enrollee to a therapeutic optometrist who is determined to be ineligible under Section [1452.206](#) and the managed care plan's charges for out-of-network services. The therapeutic optometrist and the therapeutic optometrist's professional practice may not charge the enrollee for any portion of the therapeutic optometrist's fee that is not paid or reimbursed by the enrollee's managed care plan.

Added by Acts 2013, 83rd Leg., R.S., Ch. 79 (S.B. [365](#)), Sec. 1, eff. September 1, 2013.

Sec. 1452.208. LIMITATION ON MANAGED CARE ISSUER LIABILITY. A managed care plan issuer that complies with this subchapter is not subject to liability for damages arising out of or in connection with, directly or indirectly, the payment by the issuer of an applicant therapeutic optometrist as if the therapeutic optometrist were a participating provider in the health benefit plan network.

Added by Acts 2013, 83rd Leg., R.S., Ch. 79 (S.B. [365](#)), Sec. 1, eff. September 1, 2013.